Filing at a Glance

Company:	USAble Life
Product Name:	Hospital Indemnity Applications, HIP2 & HIP2-R - R
State:	Arkansas
TOI:	H14I Individual Health - Hospital Indemnity
Sub-TOI:	H14I.000 Health - Hospital Indemnity
Filing Type:	Form
Date Submitted:	01/16/2013
SERFF Tr Num:	LSVX-G128852614
SERFF Status:	Closed-Approved
State Tr Num:	
State Status:	Approved-Closed
Co Tr Num:	AR001930100004
Implementation Date Requested:	01/16/2013
Author(s):	SPI Life and Specialty Ventures
Reviewer(s):	Donna Lambert (primary)
Disposition Date:	01/17/2013
Disposition Status:	Approved
Implementation Date:	

State Filing Description:

State: *Arkansas* **Filing Company:** *USAble Life*
TOI/Sub-TOI: *H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity*
Product Name: *Hospital Indemnity Applications, HIP2 & HIP2-R - R*
Project Name/Number: *Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004*

General Information

Project Name: Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R
Project Number: AR001930100004
Requested Filing Mode: Review & Approval
Explanation for Combination/Other:
Submission Type: New Submission
Overall Rate Impact:

Deemer Date:
Submitted By: SPI Life and Specialty Ventures

Status of Filing in Domicile:

Date Approved in Domicile:
Domicile Status Comments:
Market Type: Individual
Individual Market Type:
Filing Status Changed: 01/17/2013
State Status Changed: 01/17/2013
Created By: SPI Life and Specialty Ventures
Corresponding Filing Tracking Number:

Filing Description:

We are filing, for your review and approval, revised Hospital Confinement Indemnity applications. They have been revised pursuant to the MIB requirement to change the MIB authorization to comply with final HIPAA Regulations.

HIP2-APP (1-13) and HIP2-HSA-APP (1-13) will replace the previously approved HIP2-APP (8-07) and HIP2-HSA-APP (8-07), which were approved on 8/17/2007 under SERFF Filing ID LSVX-125262640 (AR Filing ID 36663). They can be used with our Hospital Confinement Indemnity Policy, HIP2 (3-07), which was approved on 3/19/2007 under SERFF Filing ID LSVX-125118855 (AR Filing ID 35256).

HIP2-RAPP (1-13) will replace the previously approved HIP2-RAPP (6-11), which was approved on 12/15/2011 under SERFF Filing ID LSVX-G127900447 (AR Filing ID 50489). It can be used with our Hospital Confinement Indemnity Policy, HIP2-R (3-07), which was approved on 10/20/2011 under SERFF Filing ID LSVX-G127566147 (AR Filing ID 49795).

We made the following revision to these applications: In the authorization section, added the phrase "(c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB."

The following form was previously approved by your department and will be also be used with these forms:

APP-NOTICE (9-08) - Application Notice - 10/23/2008

These applications may, at some time in the future, be converted to electronic documents. Such adaptation may slightly alter the appearance of these documents, but we assure that their content will not change and their readability compliance will not be affected.

Company and Contact

Filing Contact Information

Rob Wittenburg, Legal Product Specialist
PO Box 1650
Little Rock, AR 72203-1650
rwittenburg@usablelife.com
501-212-8877 [Phone] 8877 [Ext]
501-235-8484 [FAX]

State: *Arkansas* ***Filing Company:*** *USAble Life*
TOI/Sub-TOI: *H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity*
Product Name: *Hospital Indemnity Applications, HIP2 & HIP2-R - R*
Project Name/Number: *Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004*

Filing Company Information

USAble Life
PO Box 1650
Little Rock, AR 72203-1650
(501) 375-7200 ext. [Phone]

CoCode: 94358
Group Code: 876
Group Name: Life and Speciality Ventures (LSV)
FEIN Number: 71-0505232

State of Domicile: Arkansas
Company Type: Life & Healh
State ID Number:

Filing Fees

Fee Required? Yes
Fee Amount: $150.00
Retaliatory? No
Fee Explanation:
Per Company: No

Company	Amount	Date Processed	Transaction #
USAble Life	$150.00	01/16/2013	66604248

SERFF Tracking #:	*LSVX-G128852614*	***State Tracking #:***		***Company Tracking #:***	*AR001930100004*

State:	*Arkansas*	***Filing Company:***	*USAble Life*
TOI/Sub-TOI:	*H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity*		
Product Name:	*Hospital Indemnity Applications, HIP2 & HIP2-R - R*		
Project Name/Number:	*Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004*		

Correspondence Summary

Dispositions

Status	Created By	Created On	Date Submitted
Approved	Donna Lambert	01/17/2013	01/17/2013

SERFF Tracking #:	*LSVX-G128852614*	***State Tracking #:***		***Company Tracking #:***	*AR001930100004*

State:	*Arkansas*	***Filing Company:***	*USAble Life*
TOI/Sub-TOI:	*H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity*		
Product Name:	*Hospital Indemnity Applications, HIP2 & HIP2-R - R*		
Project Name/Number:	*Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004*		

Disposition

Disposition Date: 01/17/2013
Implementation Date:
Status: Approved

Comment:

Rate data does NOT apply to filing.

Schedule	Schedule Item	Schedule Item Status	Public Access
Supporting Document	Flesch Certification	Approved	Yes
Supporting Document	Application	Approved	Yes
Supporting Document	Health - Actuarial Justification	Approved	Yes
Supporting Document	Outline of Coverage	Approved	Yes
Supporting Document	Statement of Variability	Approved	Yes
Form	Hospital Confinement Policy Application & Change Form	Approved	Yes
Form	Hospital Confinement Policy Application & Change Form	Approved	Yes
Form	Hospital Confinement Policy Application & Change Form	Approved	Yes

SERFF Tracking #:	*LSVX-G128852614*	***State Tracking #:***		***Company Tracking #:***	*AR001930100004*

State:	*Arkansas*	***Filing Company:***	*USAble Life*
TOI/Sub-TOI:	*H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity*		
Product Name:	*Hospital Indemnity Applications, HIP2 & HIP2-R - R*		
Project Name/Number:	*Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004*		

Form Schedule

Lead Form Number: HIP2-APP (1-13)

Item No.	Schedule Item Status	Form Name	Form Number	Form Type	Form Action	Action Specific Data		Readability Score	Attachments
1	Approved 01/17/2013	Hospital Confinement Policy Application & Change Form	HIP2-APP (1-13)	AEF	Revised	Previous Filing Number:	36663	47.700	HIP2-APP (1-13).PDF
						Replaced Form Number:	HIP2-APP (8-07)		
2	Approved 01/17/2013	Hospital Confinement Policy Application & Change Form	HIP2-HSA-APP (1-13)	AEF	Revised	Previous Filing Number:	36663	47.700	HIP2-HSA-APP (1-13).PDF
						Replaced Form Number:	HIP2-HSA-APP (8-07)		
3	Approved 01/17/2013	Hospital Confinement Policy Application & Change Form	HIP2-RAPP (1-13)	AEF	Revised	Previous Filing Number:	50489	47.700	HIP2-RAPP (1-13).PDF
						Replaced Form Number:	HIP2-RAPP (6-11)		

Form Type Legend:

ADV	Advertising	**AEF**	Application/Enrollment Form
CER	Certificate	**CERA**	Certificate Amendment, Insert Page, Endorsement or Rider
DDP	Data/Declaration Pages	**FND**	Funding Agreement (Annuity, Individual and Group)
MTX	Matrix	**NOC**	Notice of Coverage
OTH	Other	**OUT**	Outline of Coverage
PJK	Policy Jacket	**POL**	Policy/Contract/Fraternal Certificate
POLA	Policy/Contract/Fraternal Certificate: Amendment, Insert Page, Endorsement or Rider	**SCH**	Schedule Pages

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USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc.	

☐ New Application ☐ Change Form ☐ Replaces Policy No. _____

SECTION 1 – PERSONAL IDENTIFICATION

Name (First, MI, Last)	For Name Change, Give Prior Last Name			Social Security #	
Home Address	City	State	Zip	County	
Name of Employer	Date Employed Full-Time	Occupation		Height (ft-in)	Weight (lbs.)
Date of Birth	Birth State or Country	Sex	Work Phone	Home Phone	

SPOUSE & CHILDREN INFORMATION - Complete if Applying for Dependent's Coverage

Person Proposed for Insurance Show first, middle, last name	Date of birth mo.	day	yr.	Birth State or Country	Marital Status	Age	Sex	Height (ft-in)	Weight (lbs.)
(spouse)									
(child)									
(child)									
(child)									
(child)									

SECTION 2 – PLAN SELECTION ■ New Applicant ■ Application for Change

CHECK COVERAGE DESIRED:

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Applicant, Spouse & Children

Hospital Confinement Plan(s):

☐ Plan I - $50 Daily Hospital Confinement, $100 Emergency Accident, $1,000 Surgery & Anesthesia, $250/$500 Ambulance Ground/Air, and Specified Injury.

☐ Plan II - $100 Daily Hospital Confinement, $250 Emergency Accident, $1,500 Surgery & Anesthesia, $75 Outpatient Sickness, $250/$500 Ambulance Ground/Air, $75 Wellness, and Specified Injury.

☐ Plan III - $200 Daily Hospital Confinement, $500 Emergency Accident, $2,500 Surgery & Anesthesia, $75 Outpatient Sickness, $500/$1,000 Ambulance Ground/Air, $75 Wellness, and Specified Injury.

Add	Delete	Optional Rider(s):	Amount		
☐	☐	Annual Hospital Admission Rider	☐ $500	☐ $750	☐ $1,000
☐	☐	Hospital Intensive Care Confinement Rider	☐ $200	☐ $400	☐ $600
☐	☐	Heart Attack, Stroke, Coma & Paralysis Benefit Rider	☐ $1,000/$500	☐ $2,000/$1,000	

Total Monthly Premium: $_____

1. Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____

   If "No", list all other Hospital Indemnity policies and their daily benefit(s). _____

2. Have you received the Outline of Coverage (in those states where required by law)? ☐ Yes ☐ No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded; (b) state that I have read and understand the "Important Note and the Insurance Fraud Warning" on page 2 of this application; (c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or MIB having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (f) agree that this authorization shall be valid for two (2) years from the application date; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (h) acknowledge receipt of written notification describing the use of the (MIB) as required by the Fair Credit Reporting Act; and (i) acknowledge receipt of the Information Practices Notice and the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void the policy.

Be sure to complete the Beneficiary & Medical Information on page 2/reverse side.

Signed at: _____ (City and State) Date of Application _____ (Month, Day, Year)

Date Received Home Office

X _____ Agent's Signature

X _____ Applicant's Signature

Employee's Name (Last, First, M.I.)	Social Security #	Employer Name

SECTION 3 – BENEFICIARY ■ **Name Beneficiary** ■ **Change of Beneficiary**

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Birthdate	Relationship	Primary or Secondary	Indicate Percentage
			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ Secondary	

SECTION 4 – MEDICAL INFORMATION

1. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a physician? If "Yes," list person(s) and details: Yes ☐ No ☐

   Person(s): _____ Details: _____

2. Has anyone to be covered been confined in a hospital or nursing home within the last 12 months because of internal cancer, melanoma, heart surgery, heart attack, congestive heart failure, vascular disease, hypertension, chronic obstructive pulmonary disease, chronic liver disease, stroke, emphysema, sickle-cell anemia, asthma, chronic bronchitis, Parkinson's disease, multiple sclerosis, or rheumatoid arthritis? ☐ ☐

   Person(s): _____ Details: _____

3. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Alzheimer's disease, senile dementia, systemic lupus, kidney failure, diabetes, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)? ☐ ☐

   Person(s): _____ Details: _____

4. Is anyone to be covered now pregnant? ☐ ☐

   Person(s): _____ Details: _____

5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? ☐ Yes ☐ No If "Yes," list person(s), medications taken, medication dosage and last two blood pressure readings. Person(s): _____

   Medication, Dosage, Readings with Dates: _____

The person(s) named above in questions 1 through 5 may be excluded from coverage by an Exclusion rider to be signed by the applicant prior to policy issuance.

6. PRIMARY PHYSICIAN'S NAME: _____ Address: _____

   Phone Number: _____ City, State, Zip: _____

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

Insurance Fraud Warning - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and subject to fines and confinement in prison.

Please Print Using Dark Ink

USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc.	

☐ New Application ☐ Change Form ☐ Replaces Policy No. _____

SECTION 1 – PERSONAL IDENTIFICATION

Name (First, MI, Last)	For Name Change, Give Prior Last Name			Social Security #	
Home Address	City	State	Zip	County	
Name of Employer	Date Employed Full-Time	Occupation		Height (ft-in)	Weight (lbs.)
Date of Birth	Birth State or Country	Sex	Work Phone	Home Phone	

SPOUSE & CHILDREN INFORMATION - Complete if Applying for Dependent's Coverage

Person Proposed for Insurance Show first, middle, last name	Date of birth mo.	day	yr.	Birth State or Country	Marital Status	Age	Sex	Height (ft-in)	Weight (lbs.)
(spouse)									
(child)									
(child)									
(child)									
(child)									

SECTION 2 – PLAN SELECTION ■ New Applicant ■ Application for Change

CHECK COVERAGE DESIRED:

☐ Applicant ☐ Applicant & Spouse ☐ Applicant & Children ☐ Applicant, Spouse & Children

Hospital Confinement Plan(s):

☐ Plan I - $50 Daily Hospital Confinement, $100 Emergency Accident, $500 Annual Hospital Admission, $200 Hospital Intensive Care.

☐ Plan II - $100 Daily Hospital Confinement, $250 Emergency Accident, $750 Annual Hospital Admission, $400 Hospital Intensive Care.

☐ Plan III - $200 Daily Hospital Confinement, $500 Emergency Accident, $1,000 Annual Hospital Admission, $600 Hospital Intensive Care.

Total Monthly Premium: $_____

1. Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company. _____

   If "No", list all other Hospital Indemnity policies and their daily benefit(s). _____

2. Have you received the Outline of Coverage (in those states where required by law)? ☐ Yes ☐ No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded; (b) state that I have read and understand the "Important Note and the Insurance Fraud Warning" on page 2 of this application; (c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or MIB having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (f) agree that this authorization shall be valid for two (2) years from the application date; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (h) acknowledge receipt of written notification describing the use of the (MIB) as required by the Fair Credit Reporting Act; and (i) acknowledge receipt of the Information Practices Notice and the Insurance Fraud Warning. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void the policy.

Be sure to complete the Beneficiary & Medical Information on page 2/reverse side.

Signed at: _____ (City and State) Date of Application _____ (Month, Day, Year)

Date Received Home Office

X _____ Agent's Signature

X _____ Applicant's Signature

Employee's Name (Last, First, M.I.)	Social Security #	Employer Name

SECTION 3 – BENEFICIARY ■ **Name Beneficiary** ■ **Change of Beneficiary**

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Birthdate	Relationship	Primary or Secondary	Indicate Percentage
			☐ Primary or ☐ Secondary	
			☐ Primary or ☐ Secondary	

SECTION 4 – MEDICAL INFORMATION

1. Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a physician? If "Yes," list person(s) and details: Yes ☐ No ☐
   Person(s): _____ Details: _____

2. Has anyone to be covered been confined in a hospital or nursing home within the last 12 months because of internal cancer, melanoma, heart surgery, heart attack, congestive heart failure, vascular disease, hypertension, chronic obstructive pulmonary disease, chronic liver disease, stroke, emphysema, sickle-cell anemia, asthma, chronic bronchitis, Parkinson's disease, multiple sclerosis, or rheumatoid arthritis? ☐ ☐
   Person(s): _____ Details: _____

3. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Alzheimer's disease, senile dementia, systemic lupus, kidney failure, diabetes, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)? ☐ ☐
   Person(s): _____ Details: _____

4. Is anyone to be covered now pregnant? ☐ ☐
   Person(s): _____ Details: _____

5. Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)? ☐ Yes ☐ No If "Yes," list person(s), medications taken, medication dosage and last two blood pressure readings. Person(s): _____
   Medication, Dosage, Readings with Dates: _____

The person(s) named above in questions 1 through 5 may be excluded from coverage by an Exclusion rider to be signed by the applicant prior to policy issuance.

6. PRIMARY PHYSICIAN'S NAME: _____ Address: _____
   Phone Number: _____ City, State, Zip: _____

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy.

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USAble Life

P.O. Box 1650
Little Rock, Arkansas 72203

HOSPITAL CONFINEMENT POLICY APPLICATION & CHANGE FORM

Office Use Only	
Effective Date	
Policy Number	
Group Number	
Dept./Loc.	

☐ New Application ☐ Change Form ☐ Reinstatement Policy ☐ Replaces Policy No. _____

SECTION 1 – PERSONAL IDENTIFICATION

Name (First, MI, Last)	For Name Change, Give Prior Last Name	Social Security No.

Home Address	City	State	Zip	County

Date of Birth	Birth State or Country	Gender ☐ Male ☐ Female	Height (ft-in)	Weight (lbs.)

Occupation	Applicant's email address (if any)	Home Phone ( )	Other Phone ( )

Name of Employer	Type of Business

1. Are you a US citizen? ☐ Yes ☐ No

2. If no to question 1, have you been issued a permanent residency VISA? ☐ Yes ☐ No

3. If yes to question 2, have you lived continuously in the US or Canada for the last 6 months? ☐ Yes ☐ No

SPOUSE [& CHILDREN] INFORMATION - Complete if Applying for Dependent's Coverage

Full Name	Occupation	Gender	Date of Birth mo	day	yr	Birth State or Country	Height ft /in	Weight lbs
(spouse)								
[child]								
[child]								
[child]								

SECTION 2 – PLAN SELECTION ☐ New Applicant ☐ Application for Change

CHECK COVERAGE DESIRED: ☐ Applicant ☐ Applicant & Spouse [☐ Applicant & Children ☐ Applicant, Spouse & Children]

Hospital Confinement Plan(s): **PREMIUM**

☐ Plan I - $50 Daily Hospital Confinement, $100 Emergency Accident, $1,000 Surgery & Anesthesia, $250/$500 Ambulance Ground/Air, and Specified Injury.

☐ Plan II - $100 Daily Hospital Confinement, $250 Emergency Accident, $1,500 Surgery & Anesthesia, $75 Outpatient Sickness, $250/$500 Ambulance Ground/Air, and Specified Injury.

☐ Plan III - $200 Daily Hospital Confinement, $500 Emergency Accident, $2,500 Surgery & Anesthesia, $75 Outpatient Sickness, $500/$1,000 Ambulance Ground/Air, and Specified Injury. $

☐ Optional Annual Hospital Admission Rider	☐ $500	☐ $750	☐ $1,000	$
☐ Optional Hospital Intensive Care Confinement Rider	☐ $200	☐ $400	☐ $600	$
☐ Optional Heart Attack, Stroke, Coma & Paralysis Benefit Rider	☐ $1,000/$500		☐ $2,000/$1,000	$

TOTAL MONTHLY PREMIUM: $_____

SECTION 3 – BENEFICIARY ☐ Name Beneficiary ☐ Change of Beneficiary

I hereby revoke the appointment of any existing beneficiary and designate the following beneficiary under this policy.

Name	Birthdate	Relationship	Primary or Contingent	Indicate Percentage
			☐ Primary or ☐ Contingent	
			☐ Primary or ☐ Contingent	
			Total must equal 100% =	

Applicant's Name (Last, First, M.I.)	Social Security No.

SECTION 4 – MEDICAL INFORMATION

		Yes	No
1.	Is anyone to be covered currently confined in a hospital or nursing home, or has hospitalization been recommended by a physician?	☐	☐
2.	Has anyone to be covered been confined in a hospital or nursing home within the last 12 months because of internal cancer, melanoma, heart surgery, heart attack, congestive heart failure, vascular disease, hypertension, chronic obstructive pulmonary disease, chronic liver disease, stroke, emphysema, sickle-cell anemia, asthma, chronic bronchitis, Parkinson's disease, multiple sclerosis, or rheumatoid arthritis?	☐	☐
3.	Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for: Alzheimer's disease, senile dementia, systemic lupus, kidney failure, diabetes, alcohol or drug abuse, Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV)?	☐	☐
4.	Is anyone to be covered currently pregnant? ☐ Yes ☐ No Has anyone to be covered ever had a problem pregnancy?	☐	☐
5.	Has anyone to be covered ever been diagnosed or treated by a member of the medical profession for hypertension (high blood pressure)?	☐	☐

If "Yes," list person(s), medications taken, medication dosage and last two blood pressure readings.

Medication, Dosage, Readings with Dates: _____

_____

The person(s) named above in questions 1 through 5 may be excluded from coverage by an Exclusion rider to be signed by the applicant prior to policy issuance.

6. Name, address and phone number of the personal physician(s): _____

_____

Give details for "yes" answers to any questions and indicate to whom answers relate.

Applicant's Name (Last, First, M.I.)	Social Security No.

SECTION 5 – AUTHORIZATION

1. Does any person applying for coverage currently have a Hospital Indemnity Policy with us or any other insurance company? ☐ Yes ☐ No
   If yes, give name of company, list type of policy and amount of coverage._____
2. REPLACEMENT: Is this insurance to replace or change other insurance? ☐ Yes ☐ No If "Yes", give details including name of company.
   _____
3. OUTLINE: Have you received the Outline of Coverage? ☐ Yes ☐ No (check one)

In signing below, I (a) represent that the statements and answers given on all pages of this application are true, complete, and correctly recorded to the best of my knowledge and belief; (b) state that I have read and understand the "Important Note" and the "Insurance Fraud Warning" below; (c) authorize USAble Life or its reinsurer to make a brief report of my personal health information to MIB; (d) authorize any physician, medical practitioner, hospital, clinic, or other medically related facility, insurance or reinsurance company, or Medical Information Bureau, Inc. having information on me or any member of my family (only those who have applied for coverage on this application) regarding our mental and physical health, other insurance coverage, hazardous activities, character, general reputation, finances, and vocation to give to USAble Life, its reinsurers, or its legal representative any and all such information to use for underwriting insurance; (e) authorize all said sources, except MIB, to give such records or knowledge to any agency employed by the company to collect and transmit such information in order to facilitate its rapid submission; (f) agree that this authorization shall be valid for two (2) years from the application date; (g) agree that a photocopy of this authorization shall be as valid as the original and I understand that a copy is available to me or my representative upon request; (h) acknowledge receipt of written notification describing the use of the Medical Information Bureau as required by the Fair Credit Reporting Act and the Notice of Insurance Information Practices. I have read and understand the above statements and agreements. In applying for insurance, I authorize my employer to make the necessary payroll deductions to pay for my insurance. I understand failure to disclose a proposed insured person's true health condition may void this policy.

IMPORTANT NOTE: The entire contract will consist of this application and the insurance issued in response to it. THE INSURANCE WILL NOT BE EFFECTIVE ON THE PROPOSED INSURED UNLESS: (1) The policy is delivered to the Owner; (2) The first modal premium is paid; (3) There has been no change since the date of this application and the effective date of the policy in the health of the Proposed Insured as stated in this application; and (4) To satisfy premium deduction requirements of my employer and dating requirements of our Section 125 Plan, if applicable, I understand that my policy will be dated and become effective on the first day of the month following the Section 125 Plan effective date (anniversary date for resolicitation) or on the first day of the month following underwriting approval, whichever is later. There is no coverage until the effective date of the policy. [I understand and accept that the coverage I am purchasing does not include dependent (child) coverage except for the initial 90 days from birth or adoption as stated in the policy and that no dependent (child) will be covered for an additional time period without the prior express written consent and approval of USAble Life.]

Insurance Fraud Warning - Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance is guilty of a crime and may be subject to fines and confinement in prison.

I have read and understand the above statements and agreements.

X _____ Signed at: _____
Applicant's Signature (City and State)

Date of Application: _____
(Month, Day, Year)

Agent's Statement: I have truly and accurately recorded the information supplied by the applicant.

X _____ _____
Agent's Signature Agent's License ID Number

_____
Agent's Printed Name

Date Received Home Office

SERFF Tracking #:	*LSVX-G128852614*	***State Tracking #:***	***Company Tracking #:*** *AR001930100004*

State:	*Arkansas*	***Filing Company:***	*USAble Life*
TOI/Sub-TOI:	*H14I Individual Health - Hospital Indemnity/H14I.000 Health - Hospital Indemnity*		
Product Name:	*Hospital Indemnity Applications, HIP2 & HIP2-R - R*		
Project Name/Number:	*Hospital Indemnity Applications, IHIP, HIP2 & HIP2-R/AR001930100004*		

Supporting Document Schedules

		Item Status:	**Status Date:**
Satisfied - Item:	Flesch Certification	Approved	01/17/2013
Comments:			
Attachment(s):			
AR Readability Certification.PDF			

		Item Status:	**Status Date:**
Bypassed - Item:	Application	Approved	01/17/2013
Bypass Reason:	Not a policy filing		

		Item Status:	**Status Date:**
Bypassed - Item:	Health - Actuarial Justification	Approved	01/17/2013
Bypass Reason:	Not a rate filing		

		Item Status:	**Status Date:**
Bypassed - Item:	Outline of Coverage	Approved	01/17/2013
Bypass Reason:	Not a policy filing		

		Item Status:	**Status Date:**
Satisfied - Item:	Statement of Variability	Approved	01/17/2013
Comments:			
Attachment(s):			
HIP2-RAPP Statement of Variability.PDF			

STATE OF ARKANSAS

READABILITY CERTIFICATION

COMPANY NAME: **USAble Life**

This is to certify that the form(s) referenced below has achieved a Flesch Reading Ease Score as indicated below and complies with the requirements of Ark. Stat. Ann. Section 66-3251 through 66-3258, cited as the Life and Disability Insurance Policy Language Simplification Act.

Form Number	Score
HIP2-APP (1-13)	47.7
HIP2-HSA-APP (1-13)	47.7
HIP2-RAPP (1-13)	47.7

Signed: 

Name: Sally A. Murphy

Title: Senior Counsel, Chief Compliance Officer and Assistant Secretary

Date: 1/16/2013

STATEMENT OF VARIABILITY

Any use of variability shall be administered in a uniform and non-discriminatory manner and shall not result in unfair discrimination.

SPECIFIC VARIABLES
HIP2-RAPP

Section 1 – Personal Identification

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

Section 2 – Plan Selection

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.

Section 5 – Authorization

1. All language regarding dependent children can be removed if the policy does not provide coverage for dependent children.